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Philadelphia College of Osteopathic Medicine

Department of Psychology

ASSESSMENT OF RISK AND PROTECTIVE FACTORS FOR HOMELESSNESS:
PRELIMINARY VALIDATION OF THE LIFE NEEDS INVENTORY

By Dena L. Brown-Young

Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Psychology

May 2006

**PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE
DEPARTMENT OF PSYCHOLOGY**

Dissertation Approval

This is to certify that the thesis presented to us by DENA BROWN YOUNG
on the 24th day of may, 2006, in partial fulfillment of the
requirements for the degree of Doctor of Psychology, has been examined and is
acceptable in both scholarship and literary quality.

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Finally, I wish to dedicate this work to every individual who is enduring the struggle for shelter, as well as to all those who are persevering in the battle, for societal understanding of homelessness as an indisputably grave aspect of the human condition.

Abstract

The purpose of this study was to examine the LNI (Life Needs Inventory), used by the VOADV (Volunteers of America Delaware Valley) organization to identify risk factors, as well as protective strengths, associated with the securing of stable housing among the homeless population. Homelessness is a growing concern in the United States (Rosenberg, Solarz, & Bailey, 1991) and individuals or families who become homeless are at risk for many more problems. Finding suitable shelter is just the beginning, as physical safety and mental health issues become major concerns. Violence, drugs, risky sexual behaviors, lack of social support, limited employment opportunities, financial instability, and mental disorders, such as depression, anxiety, schizophrenia, antisocial personality, post traumatic stress, as well as substance use, only add to the problems of homelessness. All of these issues, and more, must be considered when planning psychotherapeutic treatment for clients living in temporary shelters or transitional housing facilities. It is essential for the VOADV to have a valid and reliable instrument with which to assess the risk factors associated with homelessness, as well as to measure the impact of protective factors on homeless individuals, because these factors relate to the securing of stable housing. This study attempts to begin the validation process of the LNI.

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Past the beggar and the suffering
walked he who asks,
“Why, oh God, do you not
do something for these people?”
To which God replied,
“I did do something,
I made you.”

Old Sufi Saying

Statement of the Problem: A Need for Better Assessment

Homeless individuals often present with a myriad of complicated social and interpersonal problems. Many times, the homeless individual may be struggling with preexisting, but undiagnosed, mental health issues. In order to serve this population effectively, via the appropriate referrals for community resources, social services, and psychological interventions, a thorough understanding both of risk and of protective factors is necessary. Currently no normative data exists to describe the psychometric properties of the Life Needs Inventory (LNI), so it cannot be said that the LNI is representative of a valid and reliable instrument. Examination of the LNI will provide support for the ability of the measurement tool to identify certain factors that may assist clients in reaching their goals, as well as those specific factors that may present challenges.

The Volunteers of America Delaware Valley (VOADV) organization is dedicated to providing clients with services that are effective, as well as services that are driven by empirical research. The preliminary validation of the LNI is important because it will increase the degree of confidence in the utility of the instrument as an effective measurement device. A valid and reliable assessment instrument is needed in order to appreciate the impact of risk and protective factors as they relate to homelessness, to provide a basis for making case planning decisions, to make appropriate referrals for psychological services, to understand limitations of interventions, and to identify positive lifestyle changes in homeless clients. Because the LNI assessment is already being utilized by the VOADV, standardization will be necessary in order to justify its continued

use, to help guide the effectiveness of its administration, and eventually to establish normative data that may drive future research.

Purpose of the Study: Need for a Standardized Assessment

This examination is a first step in the validation and standardization process. The LNI requires standardization in order to establish it as a valid and reliable measure for the VOADV in obtaining information regarding client history, and in order to predict future client behavior. Tools such as the LNI can usually cover broad areas and are easy to administer in a short period of time. This fact makes their use attractive because they are cost-effective. Standardized assessments go through a precise development process in an effort to establish norms. These norms then provide information regarding the performance of a normal sample of the population and can be used to compare the performance of other individuals or groups. This is the intended process for the LNI, beginning with this preliminary research project.

Some characteristics of standardized assessments are procedure uniformity, understandable administration instructions, and previously established validity and reliability (Crist, 1998). Norms are also characteristic of standardized assessments; therefore, the ultimate establishment of norms for the LNI is the purpose of this gateway project. There will be more confidence in the LNI after it has undergone stringent statistical analysis to develop norms and to establish validity and reliability.

With a validated measuring tool, assessment of homeless individuals can be made more efficiently; it will also be made with more confidence that the information gleaned will be useful in effective treatment planning. The assessment of risk and protective factors for a homeless individual is important, because it uncovers possible challenges

with which the individual may be faced when trying to secure and maintain stable housing, as well as those factors that may increase the likelihood that the individual will be successful at reaching his or her specified goals on the service plan. More services, or more intensive services, may be recommended for an individual with a higher level of risk. Ultimately, the appropriate service plan, driven by the information obtained from the LNI, may aid an individual in his or her search for housing, and may also facilitate a decrease in an individual's rate of return to homelessness. Assessment of problems and strengths provides information that helps the VOADV better serve the homeless population.

Rationale for Validation of the LNI

The rationale for this research project stems from the fact that homelessness is a significant concern for the VOADV, as well as for other agencies servicing this population. There is a crucial need for a valid and reliable assessment tool that identifies risk and protective factors associated with the securing of stable housing for the homeless. With this information, effective treatment plans can be developed and appropriate referrals to other agencies, such as mental health agencies, substance abuse programs, and welfare services can be made.

The goal of this study was to examine the psychometric properties of the LNI, already in use by the VOADV, and to begin to establish a set of normative data to be used in future comparisons of LNI data. Statistical procedures were used to analyze the validity and reliability of the LNI and to identify any correlations between the 13 categories of the instrument. In addition, an examination of the 145 individual items represented on the LNI provided a better understanding of those items that actually

constitute risk factors or protective factors. Gender and racial comparisons were made in an effort to uncover any noteworthy differences between males and females, as well as between African Americans, Latinos, and Caucasians, and also to determine if the LNI has equal application among all of these groups.

It was anticipated that the information obtained from this study would positively influence the effectiveness of the VOADV to serve the homeless population. The statistical data provided by this research clarifies which, as well as how risk factors and protective factors must be considered when working therapeutically with the homeless population.

Homelessness in America

In the 1950's and 1960's, the homeless population consisted primarily of older white men. They were usually confined to specific areas and were not as visible as are the homeless today. Presently the homeless population has increased to include a younger, more heterogeneous grouping of individuals who are more highly educated, more likely to use drugs and alcohol, have more physical and mental illness, and are much more publicly visible (McCarty, Argeriou, Huebner, & Lubran, 1991). Children are frequently viewed as victims and generally invoke sympathy; however, individuals with mental illness are usually thought to be the cause of their own homelessness and often invoke blame (Steinhaus, Harley, & Rogers, 2004).

Much of the homeless population today consists of women of color from urban areas. Many of these women have children, usually two or three, below the preschool age. The correlates to homelessness are many, including poverty, limited employability, social isolation, mental illness, alcoholism and drug abuse, and domestic violence. All of

these issues, and more, may need to be explored when working therapeutically with homeless clients.

Psychological Implications of Homelessness

There are several determinants that may contribute to homelessness. Mental illness may be considered one of the major concerns. Although many psychological disorders exist among individuals prior to their becoming homeless, many of these psychological disorders are not diagnosed until after these individuals become homeless. These disorders include, but are certainly not limited to depression, anxiety, schizophrenia, substance use disorders, and antisocial personality disorder. Other issues connected to homelessness are trauma associated with sexual abuse, physical abuse, and domestic violence, as well as problems with interpersonal relationships, problems with the social environment, problems with the legal system, psychological distress stemming from medical conditions, and complications as a result of a physical disability.

Domestic Violence

Many women and some men may find themselves homeless because of domestic violence. When treating these clients, a focus on the effects of this abuse is important. The mental health of their children is also of great concern. Childhood depression, anxiety, and behavioral problems have been reported in children who have been exposed to or who have been victims of domestic violence (Sternberg, Lamb, Greenbaum, Cicchetti, Dawud, Cortes, Krispin, & Lorey, 1993).

Residential instability, school change, poor nutrition, exposure to family or neighborhood violence, and parental mental health and substance abuse problems are common stressors for the children of homeless families (Buckner, Bassuk, Weinreb, &

Brooks, 1999). Many of the children's physical, mental, and educational problems result from these stressors. As these problems with the children increase, the stressors placed on the parents and the families increase as well. Unfortunately, this may foster the negative cycle of domestic violence.

It is interesting to note that many homeless people have had several negative incidents during childhood that may have made them vulnerable and at risk for later homelessness, but many have sizeable, overall social networks and are in regular contact with family and friends (Toro, Bellavia, Daeschler, Owens, Wall, Pasero, & Thomas, 1995).

During treatment, it is important to address the individual's perceived reasons for his or her current situation of homelessness. This may be done through the use of cognitive therapy. The aim is to increase the use of social network resources, and to work on a behavioral plan that strives to prevent any future recurrences of domestic violence.

Drug Dependence and Abuse

A significant amount of homelessness is the result of alcoholism and drug abuse (Abel & Cummings, 1993). Alcohol and other drug abuse may be viewed either as a cause or as a consequence of homelessness. Sometimes these substances are used, preceding and also following homelessness as coping mechanisms to deal with unemployment or economic problems. Short-term detoxification remedies for alcohol and other drug abuse, without adequate employment and affordable housing, simply send the abusers back to their original coping mechanisms, drugs or alcohol, to deal with unemployment and homelessness once again (Abel & Cummings, 1993). As a result,

there is growing interest in the long-term effects and causes of homelessness as they relate to alcohol and other drug abuse.

Alcohol and other drugs are related to liver disease, serious traumas, seizure disorders and other neurological impairments, as well as, to nutritional deficiencies (Abel & Cummings, 1993). Because health problems may increase, due to the abuse of alcohol and drugs, this may be an important area of concern in treatment.

Although homeless people with substance abuse problems and mental disorders have the greatest need for support services, they are the most disadvantaged and underserved group in the homeless population (Stein & Gelberg, 1995). There are also those individuals with substance abuse problems and mental disorders who have children. Unfortunately, some mothers who are currently using drugs may have abused alcohol and other substances while they were pregnant. Thus their children are negatively affected, both biologically and environmentally, by drugs and alcohol. This area must be addressed at the beginning of psychological treatment. Harm reduction is of the utmost importance if therapy is to continue.

HIV and STD's

“Survival sex” has become a way of life for many homeless individuals. There is an exchange of sex for food, clothing, and shelter (Liverpool, McGhee, Lollis, Beckford, & Levine, 2002). This type of risky sexual behavior makes people even more vulnerable to contraction of HIV and other STD's. This activity also places individuals in more situations where they are participating in unprotected sex with multiple partners and many of these partners may be intravenous drug users.

Liverpool et al. (2002) concluded that homeless individuals had a strong knowledge of HIV/AIDS; however, the use of condoms was not consistent with this knowledge. Sexual behavior and attitudes continue to be risky among the adolescent population of the homeless. It is important to note, however, that nationwide polls do not reveal much difference in the sexual behavior and attitudes of adolescents who are not at risk (Liverpool et al., 2002). The prevention of HIV/AIDS among this group is based on the ability of the educator to modify the sexual behavior of these young people through the complete understanding of adolescents in cognitive and behavioral contexts (Liverpool et al., 2002).

More and more adolescents are becoming homeless. They are living on the street, in group homes, or in shelters. Risky sexual and drug-abusing activities are dangerously common among these homeless adolescents (Liverpool et al. 2002). As a result of “survival sex” behaviors, combined with the lack of condom use, these young people are at an even greater risk for infection than the general population of adolescents. This matter of life and death is a significant issue to address in therapy not only with adolescents, but also with the adult population of homeless individuals.

Social Isolation

Homelessness brings with it a myriad of emotional problems. A feeling of isolation from society is a major factor. A study conducted by Shinn, Knickman, and Weitzman (1991) concluded that more than three fourths of the women in the study who were seeking shelter had already stayed with family members and had used up their social resources before turning to public assistance. Also, these women had a higher prevalence of adult and childhood disruptions in social relationships.

Strong social ties may be an important factor in the prevention of homelessness. The development of social skills and other interpersonal relationship skills should be a focus of treatment for homeless individuals, especially when family ties are nearby, but are not considered as a resource.

Depression

Some families experience a breakdown of relationships while living in temporary housing. Lindsey (1998) noted three dynamics: public mothering, the unraveling of the mother role, and the mother's experience of being externally controlled by shelter rules. As these dynamics may be difficult for mothers to deal with and may precipitate or perpetuate depression, these may need to be addressed in therapy.

A lack of support services may be another factor in depression. In emergency shelters, families must obtain food on their own. Cooking is not usually permitted and food stamps are often inadequate (Leticq, Anderson, & Koblinsky, 1998). These types of facilities do not have support services, such as childcare and employment assistance, and restrict residency to such short periods of time that families are not able to obtain adequate employment or appropriate permanent housing (Leticq, et al., 1998).

Loneliness

The homeless tend to be much more depressed than the general population (Bogard, McConnell, Gerstel, & Schwartz, 1999). There are many possible reasons for this. Loneliness may have much to do with depression in the homeless. Social isolation, from the original neighborhood may be a factor because some individuals are housed at a distance from relatives, neighbors, and friends. Also, separation from a partner, even in cases of domestic violence, can cause loneliness and increased levels of depression

(Bogard, et al., 1999). This loneliness may strengthen a client's motivation to reunite with an abusive partner, thus a desire to return to an abusive or violent environment should be a focus of therapy.

Distrust

There may be an enormous amount of psychological trauma attached to the sudden or gradual loss of a home, to the conditions of shelter life, or for many women, homelessness as a result of physical or sexual abuse from a partner (Goodman, Saxe, & Harvey, 1991). Interpersonal conflicts with family and friends that cause alienation may contribute to the distrust of others. For homeless adolescents, neglect and physical or sexual abuse from family members may have preceded their homelessness. All of these factors may create a feeling of distrust in a homeless individual.

Difficulties with social services and problems with other agencies that provide assistance may also cause an individual to develop issues of distrust. Feelings of rejection from the denial of services may contribute to psychological trauma (Goodman et al., 1991). These problems may be perceived, by the client, as a continuation of the lack of safety and protection that he or she has experienced previously. Trust must be established if any type of therapeutic relationship is expected to survive.

Employment Problems

There are several homeless mothers with limited education. Most are very young and have not graduated from high school. Many have been on public assistance and do not have stable work histories (Lindsey, 1998). Others have been primary caregivers for their children while other family members were responsible for earning money and thus, they have not gained any experience in the world of work. Even if a mother has adequate

work skills, she may not have access to appropriate childcare. Most shelters and housing facilities do not provide this service for the residents.

It is estimated that during the 1960's, over one half of the homeless were employed full-time, part-time, or on an intermittent basis. Today's working homeless make up only about 3% of the total homeless population (Rossi, 1990). Perhaps the reason is that more of today's homeless people are women and children, not single men.

Some new programs have been developed to employ previously homeless people with psychiatric disabilities. They are hired to attend social activities with currently homeless individuals who have psychiatric disabilities. This is done in an effort to address social isolation and to engage them in psychological therapy and housing programs (Fisk & Frey, 2002).

Individuals who have worked previously and have some skills may have a greater desire to obtain employment, to regain confidence, and to increase their sense of self-efficacy. This will be an important point to address in therapy. However, some young mothers have not developed any work skills and are the only available caregivers to their children. Finding employment for these individuals is extremely difficult; however, this may not be a significant issue for the client to cover in therapy.

Medical Care Issues

Medical insurance is non-existent for most homeless adults. This is a major problem for pregnant women who are homeless. The lack of prenatal care is related to perinatal mortality, low birth weight, and pre-term births (Stein, Lu, & Gelberg, 2000).

Poor nutrition, untreated chronic medical problems, substance abuse, and mental disorders, as well as the stress of homelessness contribute to poor pregnancy outcomes.

Considering the frequency of “survival sex” among the homeless, many women become pregnant while they are homeless (Stein, Lu, & Gelberg, 2000). Those with substance abuse problems may choose to seek drugs and alcohol rather than food, and generally, shelter meals are not extremely nutritious. If hygiene is difficult, vaginal infections may become problematic. If the infections are left untreated, this increases the risk of complications at birth. Often medical care is non-existent for the mother and prenatal care is not sought for the unborn child (Stein, Lu, & Gelberg, 2000). If the infant survives, there may be a host of medical needs that will, most likely, not be addressed after birth.

The medical needs of homeless adolescents are many. Some are simply malnourished. Others require interventions for drug dependence, STD's, lack of adequate immunizations, and existing untreated medical conditions (Steele & O'Keefe, 2001).

Homeless individuals may be aware that medical attention is warranted. However, the lack of ability to pay for services, the frustration caused by denial of services, and the fear of the future may be paralyzing. All of this must be taken into account during psychological treatment.

Other Financial Barriers

Support services may be scarce at times. They may be non-existent when substance abuse is a factor. However, even when substance abuse is not present, the crisis in affordable housing, reduced social welfare benefits, and increased poverty among

single women and their children contribute to the difficulty of obtaining support services for the homeless (Robertson, 1991).

Undiagnosed mental illness makes it arduous for individuals who truly need services and who are entitled to receive these services. Since the original Social Security Administration disability review and eligibility reforms in the 1970's and 1980's, it has been more difficult for mentally ill people, who qualify, to receive benefits. It is virtually impossible for homeless mentally ill individuals because they face numerous emotional, cognitive, and financial barriers to psychological, social, and medical services (Jacobs, Newman, & Burns, 2001).

For homeless individuals with or without diagnosed mental illness, outreach programs which provide emergency shelter or food can be helpful as immediate resources. However, the use of these types of programs as a means to engage these people in mental health treatment may be useless unless there are ongoing services of intensive treatment and support (Dennis, Buckner, Lipton, & Levine, 1991). Affordable housing must be somehow connected to an accessible and comprehensive array of services (Dennis et al., 1991).

Education and information about the availability of services must be provided in order for the homeless population to be able to understand what these services are and how to gain access to what is currently available. However, even more services need to be provided, and agencies need better ways to inform homeless individuals about the services that are already in place.

Social Support Services

The high crossover rate of homelessness and the use of the welfare system is evidence of the need for coordination of services for the children in homeless families (Park, Metraux, Brodbar, & Culhane, 2004). Although section 8 housing opportunities are intended to allow low income families the opportunity to compete in the housing rental market, many families are not successful in gaining access to the program (Mulroy, 1990).

Government Policy

The United States Government has developed a policy to address the problem of homelessness. The goal is to end, rather than simply to deal with the problem (Kondratas, 1991). Although emergency remedies are a good beginning, a shift to more permanent solutions is imperative. Until this goal is met, effective psychological treatments are necessary to handle the vast array of mental health issues presented by the homeless population.

Psychological Treatment Issues

Ongoing assessment should be used to monitor for negative and positive situational changes. The development of problem solving skills should be considered as a goal during treatment and decision-making techniques should be introduced during the course of therapy. Relaxation methods may prove helpful to teach clients how to cope with the many stressors associated with homelessness. Most cognitive behavioral therapeutic techniques used for the treatment of mental illness in homeless clients will be similar to those used for other clients. However, there will need to be some modifications.

When treating homeless clients, a therapist must constantly be aware that many issues may come into play. The client has no stable residence, may not have access to transportation, and will probably not have the use of a telephone. The lack of financial resources and insurance coverage will prevent the client from being able to pay for any services. Basic necessities, such as food and clothing, may not be available to the client. The client may be concerned about a lack of physical safety on the streets or in a shelter. He or she may feel that there is a constant threat of violence or sexual abuse from a partner or from another family member. The client may be engaging in risky sexual behaviors to survive or using drugs and alcohol to self-medicate and cope with stressors. HIV and other STD's will be a major concern under these circumstances. There may be other untreated medical problems or unresolved legal issues present. A client may be concerned about his or her children and the host of problematic situations faced daily. A female client may be worried about a current pregnancy and the welfare of her unborn child. There may be a lack of social support and limited employment opportunities for the client. Feelings of embarrassment, helplessness and loneliness may increase levels of depression. These are just some of the dilemmas with which a homeless client may be faced on a daily basis, and this may be combined with severe mental illness.

A lack of trust from the client may make it difficult to establish a therapeutic relationship. An open, sincere, genuine, non-threatening, non-accusatory, non-judgmental, tolerant, and caring approach will be necessary to engage and hold this client in therapy. Knowledge of support services available will be essential to begin to understand the client's situation and to educate the client if he or she is not aware of these services.

The majority of homeless clients may be young women of color, primarily African American. There may also be homeless Latinas and women of European descent, or any other ethnicity, so information about these cultures will be important to gain an idea of how homelessness may be affecting them from the perspectives of their individual backgrounds and current worldviews. In addition, there are many homeless men from many different ethnic backgrounds. Homelessness may mean something completely different to a man with a family, than it does for a single adolescent male. There may also be diverse feelings regarding homelessness among similar age groups with similar ethnic backgrounds.

Perhaps the most valuable practice for a therapist to adopt when working with homeless clients is always to focus on the individual. A complete and ongoing conceptualization of each individual client will be necessary to assess and treat the presenting problems properly.

It may be helpful to remember that many African American families, from lower socioeconomic backgrounds, are generally matriarchal. It will be important for a therapist to identify his or her own values and beliefs regarding roles within a family. Focusing on the extended family network for emotional and economic support may be beneficial. Also, spirituality and religion may play an important role, so churches should be considered as a resource for support. Perhaps the most important aspect to understand will be the impact of racism and the numerous economic problems that are associated with racism for African Americans and for other people of color.

A consideration of these points will be significant for the homeless client, no matter what age group, gender or ethnic background he or she is from. The focus must

always remain on the individual and his or her life experiences. Constant education about the groups with which the individual identifies will be useful; however, a therapist must be careful not to over generalize to the point of stereotyping.

Methods

The method of this study consisted of the statistical examination of VOADV data from three homeless facilities. Descriptive statistics were used to explain the data and to draw valid inferences about correlations that were uncovered. The 13 LNI categories were analyzed to uncover existing correlations. It is hoped that these correlations will drive future research on the LNI.

Research Hypotheses

Data collected from this sample was compressed into 13 categories of risk factors and protective factors which are represented on the Life Needs Inventory (LNI). Each category consists of several risk factors and several protective factors. It is assumed that the more risk factors an individual endorses, the higher his or her likelihood will be of remaining homeless longer, having difficulty securing housing, requiring more extensive services, or becoming homeless again in the future. The higher the protective factors are for an individual, the more likely it is that he or she will find housing in a reasonable amount of time, with little difficulty, requiring fewer community services, and that he or she will be able to maintain housing and not become homeless again in the future.

Participants

Archival data from VOADV homeless clients was used in this study to attempt an investigation of the psychometric properties of the LNI. Data from 267 homeless clients was evaluated to provide frequency distributions for demographic information, correlations between categories, and values of predictor variables.

Participants consisted of 267 homeless adults residing in one of three transitional living facilities located in Camden County, Somerset County, or Gloucester County, NJ. Each individual was temporarily housed in one of the three shelters between July 2004 and December 2004. There were 267 adults; 252 of the individuals were female and only 15 were male, with the ages ranging from 18 to 59. The race distribution of this sample included Caucasian, African-American, Hispanic/Latino, and Mixed or Multi-cultural individuals.

Study Site

The Volunteers of America Delaware Valley organization was founded on March 8th, 1896 by Ballington and Maud Booth. The Booth's were Christian social reformers who had a desire to serve American people with a broad spiritual movement. On March 30th, 1896 the first organization meeting of the VOADV was held at the Academy of Music in Philadelphia, PA. Since then, the VOADV has been assisting individuals in need in an effort to help them achieve self-determination and independent living.

The VOADV is a non-profit organization serving New Jersey, Delaware, and the Southeastern Pennsylvania metropolitan area. The organization provides 20 human service programs and offers opportunities for individuals. The VOADV also provides community involvement to serve disadvantaged children, the elderly, the homeless, those with chronic mental health issues, and ex-offenders returning to society following incarceration. Some of the programs provided by the VOADV are single adult male shelters, family shelters, homeless prevention programs, day care, latchkey, and child enrichment services, transitional housing, corrections programs, a women's work release program, subsidized housing for seniors, domestic violence outreach, juvenile offenders

ready for work programs, and special needs programs for the developmentally disabled, mentally ill, or chemically dependent.

This research project aims to begin the process of providing the VOADV with a normative data set describing the psychometric properties of the LNI. After the normative data set is established, this can then be used in comparisons with other VOADV data collected on the homeless population serviced by this organization.

The VOADV defines homelessness as being without a permanent residence of any type. This is the definition of homelessness that was adopted for the purpose of this project. Successful outcomes may be defined as exits from the VOADV programs, into permanent housing, as well as any reduction in risk factors or increases in protective factors.

Materials

Validation materials consisted of the LNI assessment tool, VOADV archival data of homeless clients from three separate shelter facilities in New Jersey, and the computer-based statistical package, SPSS 11.0 (2001).

The three shelter facilities studied are located in Camden County, 65 beds, Somerset County, 53 beds, and Gloucester County, 36 beds. Each facility provides 24-hour supervised support to single women and families with children. There are food services available, as well as some other ancillary services, such as emergency clothing, transportation, life skills, substance awareness workshops, and programs for children.

Description of Measures

The LNI is a 145-item assessment tool, developed by Marilyn Van Dietsen, Ph. D., which identifies risk and protective factors for individuals serviced by the VOADV. This tool is a four-page assessment with 13 categories of potential risk and protective factors.

The 13 categories on the LNI assessment are homelessness history, which consists of four risk factors and four protective factors; financial, which also consists of four risk factors, but has six protective factors; education, which is composed of six risk factors and five protective factors; employment, with seven risk factors and six protective factors; medical/physical, with four risk factors and three protective factors; mental health, which has seven risk factors and five protective factors; life, interpersonal skills, and social network, which lists eight risk factors and five protective factors; substance abuse, which is composed of nine risk factors and five protective factors; criminal behavior, with eight risk factors and only three protective factors; family (origin), which lists nine risk factors and six protective factors; family (current), with five risk factors and four protective factors; children/dependents, which consists of ten risk factors and six protective factors; and finally neighborhood, which lists only two risk factors and four protective factors.

The LNI is completed at intake, at three-month intervals, and at exit from the specified VOADV program. The VOADV staff member administering the LNI gives a point for each risk factor or protective factor identified. Points are totaled by the staff member to provide a total risk score and a total protective score. Although all information on the LNI is self-reported by the client, in a structured interview, the actual scores are determined by the interviewer using scoring criteria. For example, if a resident states that

he or she has confidence in his or her ability to resolve the homeless situation, the staff interviewer must be reasonably certain that the individual is being realistic and can demonstrate how he or she will achieve this goal. It is up to the interviewer to determine whether or not the resident is motivated and has the skills, resources, and ability to follow through with the plan.

With the information obtained from the LNI, a master service plan is developed, rating each area of need as either N/A, low, medium, or high. Then an individual service plan for each area of need is developed and is composed of action steps to reach short and long-term goals. The definition of a risk factor is anything that may present a challenge for a client trying to reach a goal. In contrast, a protective factor is anything that may assist the client in reaching a goal.

Data Analysis

This study included 267 adult homeless clients between the ages of 18 and 61. Only 15 participants were males and 252 were females. The racial mix of the participants was Caucasian, 82; Hispanic/Latino, 22; African American, 157; multi-racial, 4; and 2 were unlisted. Information regarding the participants was obtained from a VOADV archival data set. Statistical analysis of the LNI included descriptive statistics analyses, factor analysis of categories to identify an underlying factor structure, and item analysis for each category.

Pearson Correlations were used to identify the relationships between LNI variables. Several correlations were significant at the .01 level. Regression analysis was then conducted to estimate the values of each criterion or outcome variable based on the

predictor variables. Finally, the strength of the relationships between variables was ascertained using a multiple correlation (R).

Descriptive statistics provided means for age, gender, and race, along with the accompanying standard deviations for each score. Frequency distributions allowed for the data to be summarized and organized into meaningful groupings. The statistical tests used were Pearson correlations for LNI categories. Pearson correlations were also used to assess risk and protective factors in relation to homelessness and successful outcomes. Finally, linear regression analysis was used to identify the specific categories which contributed to the risk factor and protective factor scores.

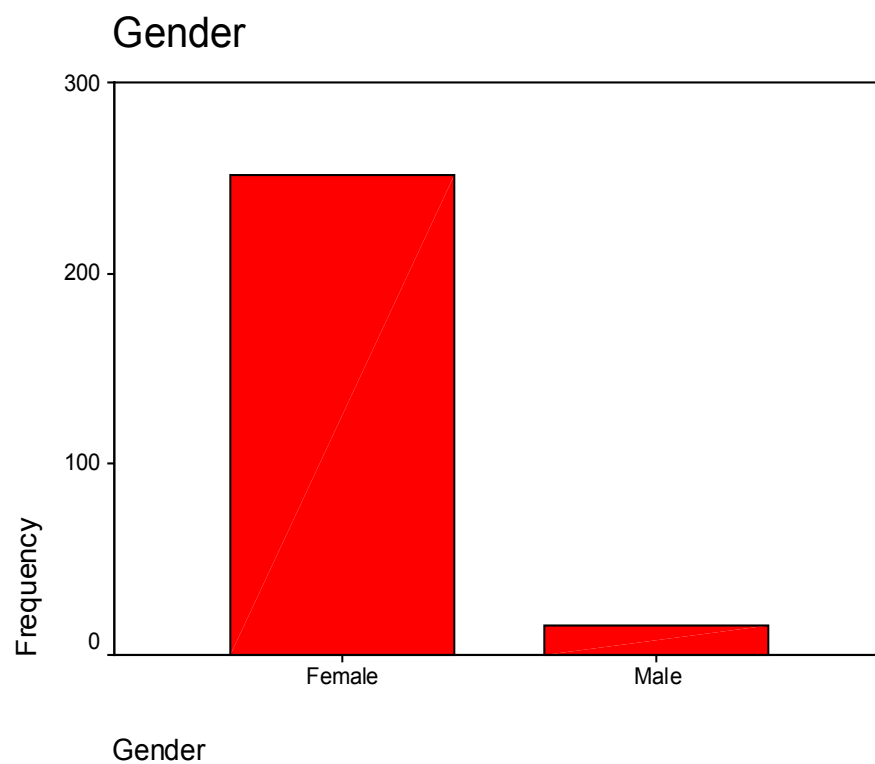
Results

Descriptive Statistics

Demographics

The sample for this study consisted of a total of 267 homeless adults. There were 167 individuals housed in the Camden County facility, 54 housed in the Somerset County facility, and 46 housed in the Gloucester County facility. Of the 167 individuals from Camden County, 10 were male. There was 1 male from Somerset County, and 4 males were from Gloucester County. Although 94.4% of the total sample was female, only 5.6% was male (see Figure 1).

Figure 1



Ages represented in this sample ranged from 18 to 59. Data was missing for 171 of the adults studied, representing 64%, so these ages are representative of only 96 of the individuals, or 36% of the sample. There were 6 adults in the 18-19 year old category and 7 adults in their 50's. There were 18 individuals in their 40's and 27 in their 30's. The largest group was 38 individuals in the age range of 20-29 years old. The mean age for this sample was 32 years old, with a standard deviation of 10. These results are summarized in Figure 2.

Figure 2

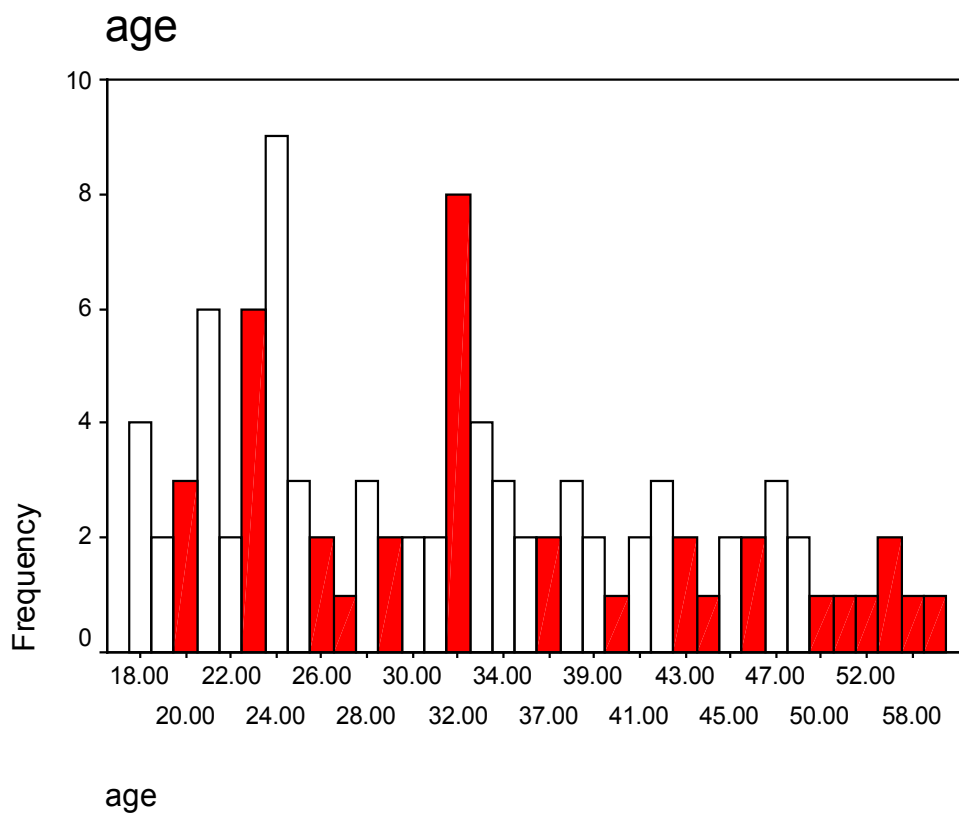
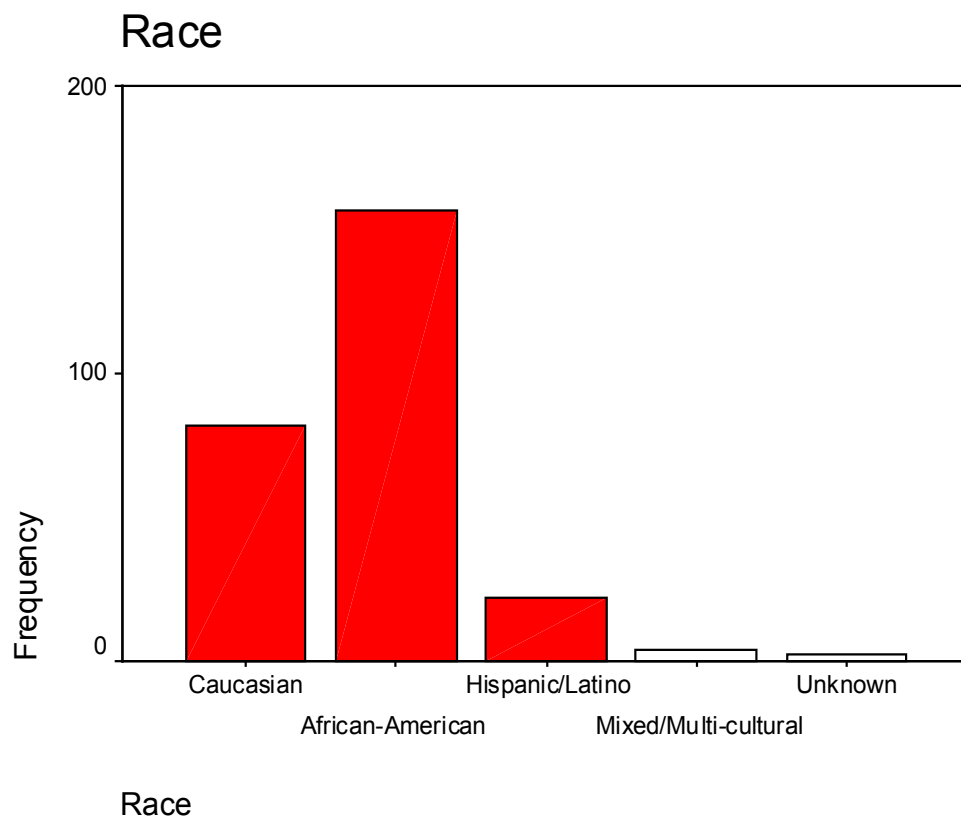


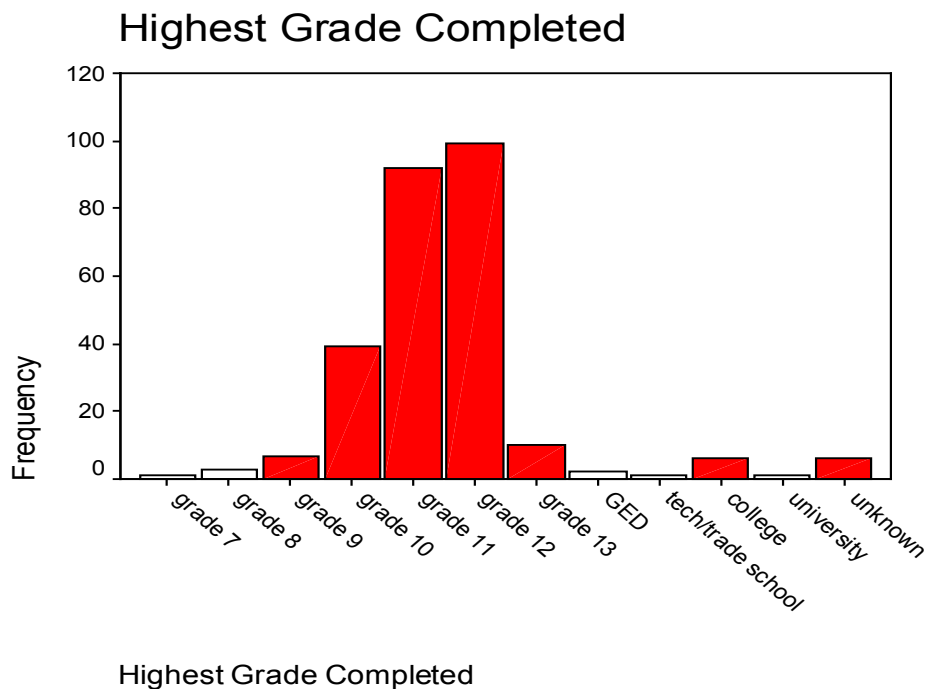
Figure 3 indicates that there were 157 African-Americans represented, which was 58.8% of the total sample. There were 82 Caucasians, and they represented 30.7% of the total. With 22 Hispanic/Latino individuals, 4 mixed/multi-cultural, and 2 individuals in the unidentified race categories, there were 8.2%, 1.5%, and .7% represented respectively.

Figure 3



A majority of the individuals in the sample, 71.6%, had completed up to grades 11 or 12, and a small percentage, 2.6%, had attended a college or university. The lowest grade, completed by only .4% of the sample, was 7th. For 6 individuals, 2.2%, information pertaining to education was unknown. Figure 4 summarizes these results.

Figure 4



Only 3 individuals, 1.2%, reported dates for their last employments. Data was missing for 264 individuals (see Figure 5). There were 232 people, 86.9%, whose funding source for their respective shelters was the Board of Social Services. Other funding sources included grants and self pay programs, as shown in Figure 6.

Figure 5

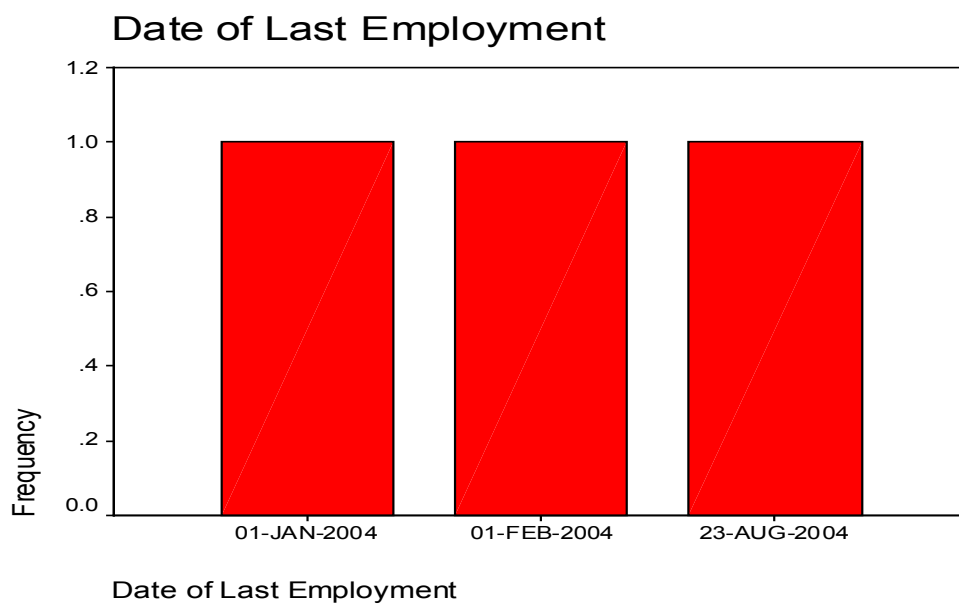
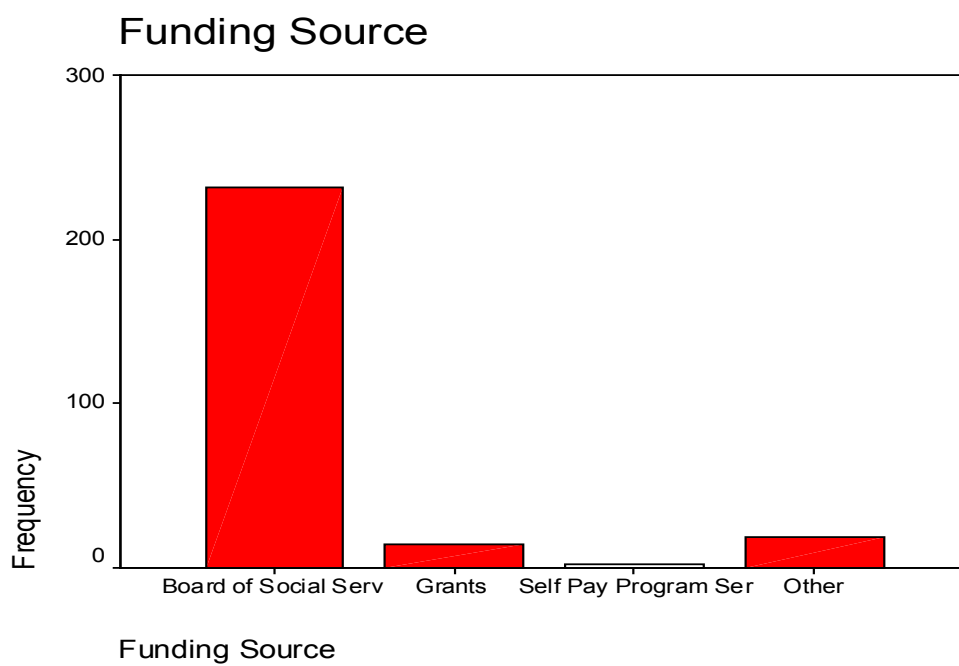
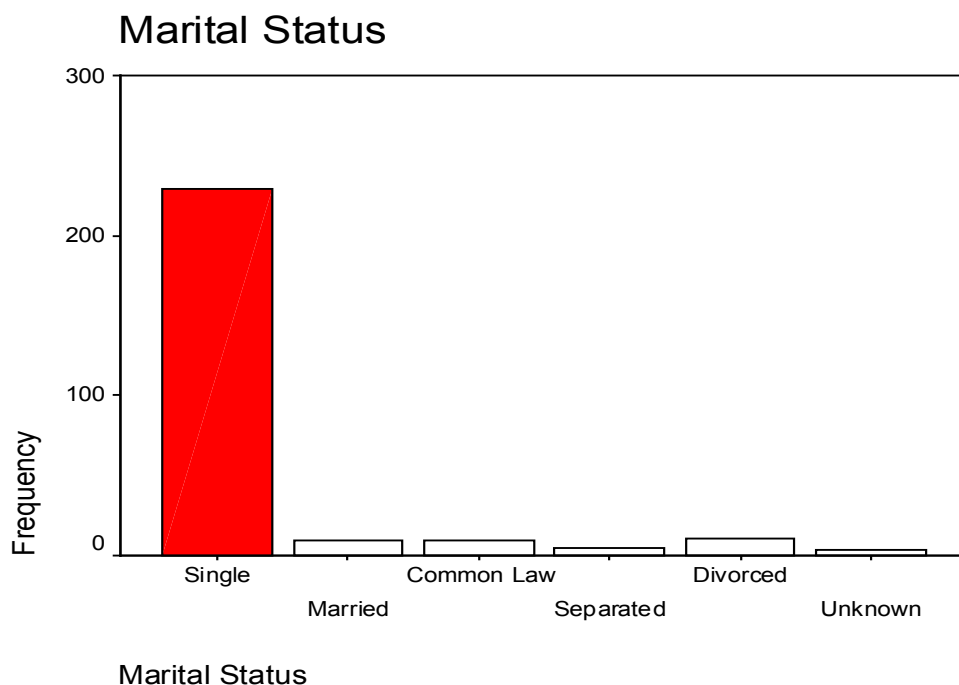


Figure 6



Most of the individuals in the sample, 229 or 85.5%, reported that they were single. There were 9 people who were married, representing 3.4%, and 10 people were in common law situations, 3.7%. Figure 7 shows that 5 individuals, 1.9%, were separated and there were 11 who were divorced, 4.1%. There were 3 people, representing 1.1%, whose information was unknown.

Figure 7



Although 42.7% of the individuals in the sample reported that they had 1 or 2 children, as shown in Figure 8, Figure 9 shows that only 38.9% reported having their 1 or 2 children with them in the shelter. The greatest number of children reported being in the shelter with one family was 6; however, 2 individuals reported having 7 children and 1 reported having 9 children, total, in the family. Data for number of children was missing for 1 individual.

Figure 8

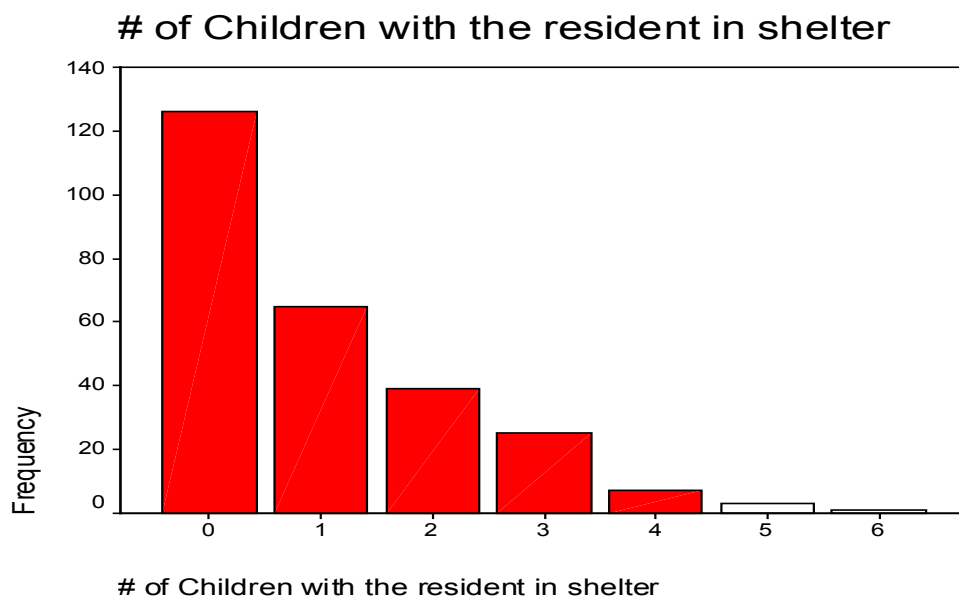
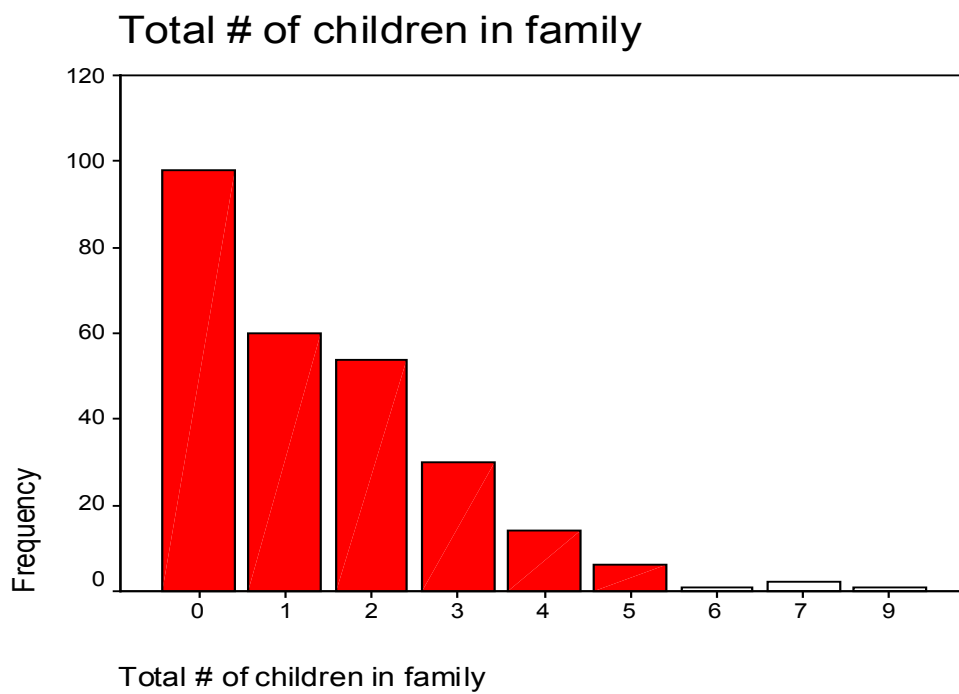
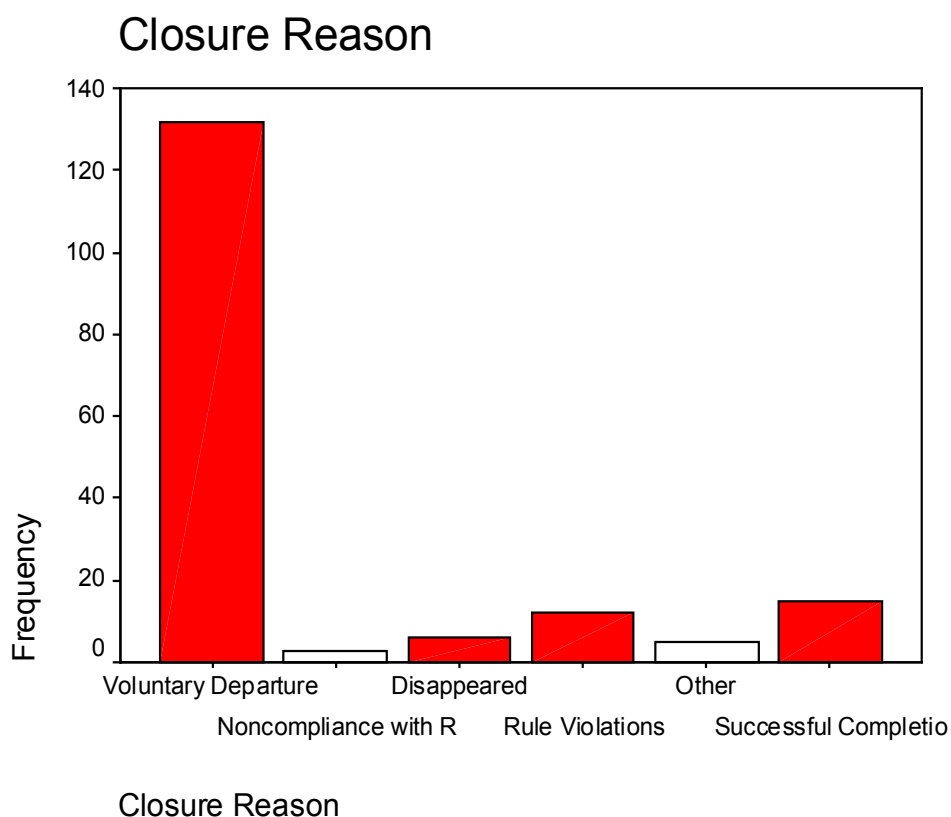


Figure 9



Data showed that the most frequently occurring reason for closure was voluntary departure; this represented 49.4% or 132 people. Other reasons included successful completions, 5.6%, meaning that the individual was able to obtain housing; rule violations, 4.5%; disappeared, 2.2%; non-compliance with requirements, 1.1%; and other 1.9%. Data describing the reasons for closure was missing for 35.2% of the sample in this study (see Figure 10).

Figure 10



At least half of the individuals in the sample, 50.2%, left one of the three facilities for permanent housing. The closure status for 7.5% of the sample was temporary housing. For 6.4%, closure status was unknown, and 1.1% of the sample transferred at closure. Closure data was missing for 34.8%, or 93 individuals.

From the demographic information obtained in this study, it appears that most individuals in the sample were single African American females between the ages of 20 and 29. Most of these women had completed up to grade 11 or had graduated from high school; however, few had recently held a job. Many of the women had 1 child or 2 children; however, several women did not have their children with them in the shelter. Most of the women's funding for their respective shelters was from the Board of Social Services and a majority of the women voluntarily left their respective shelters for permanent housing.

Risk and Protective Factors

Data was missing for 47 individuals from 12 of the risk and protective categories, so that 17.6% of the sample is not represented with risk and protective factors in these 12 categories of this study. The children and dependents category was missing data for 55 people, representing 20.6% of the sample. It is not clear if the data present for each individual is consistent throughout each category. That is, it is difficult to determine whether or not complete data is present for each of the represented individuals or whether or not for certain individuals, data from some categories is represented or if data from other categories is missing. The way in which the data was reported made it impossible to use the same individuals for each analysis.

Homelessness history: risk and protective factors. There were 192 individuals, 71.9%, who reported that this was their first homeless occurrence. The percentage of individuals who reported having been homeless two or more times in the past was 7.1%, or 19 individuals. There were 7 individuals, 2.6%, who reported having been homeless longer than one month. Only 1 person reported having been homeless before the age of 18. There was 1 person from the sample who did not endorse any risk factors for homelessness history. The reason for this may be that this individual had been homeless only once before this current homeless occurrence; however, that option is not offered as a risk factor in this category.

In the Homelessness Protective category, confidence in the ability to resolve his or her housing situation was seen in 32.6%, or 87 people. From the sample, 74 people reported the ability and willingness to access community resources; these represented 27.7%. There were 33 individuals, 12.4%, who reported having paid utilities in the past. No protective factors were identified for 26 people, representing 9.7% of the people in the sample.

Financial: risk and protective factors. No finances or limited finances were reported by 159 individuals, 59.6% of the sample. A history of financial instability was reported by 19.1% of the sample, 51 people. There were 4 people, only 1.5%, who reported that they were being court ordered to pay child support. No risk factors were reported by 6 individuals, who represent 2.2% of the sample. The same percentage of individuals, 2.2%, did not report any protective factors. There were 45 people, 16.9%, who reported confidence in their abilities to address their financial concerns. A large percentage 49.8%, or 133 individuals, were eligible for assistance or had some financial

resources. This study identified 30 individuals, representing 11.2% of the sample, who were eligible for Section 8 housing. Only 1.9% of the sample, 5 people, reported having a current or previous checking or savings account. Having previously filed for bankruptcy was reported by only 1 person, .4% of the sample. 6 people, 2.2%, did not endorse any protective factors in the finance category.

Education: risk and protective factors. There were 88 people, 33% of the sample, who reported completing less than a 10th grade education. Twenty-five people, 9.4% of the sample, reported that they had less than a 12th grade education. Academic difficulties were reported by 40 individuals, 15%. A history of behavioral problems was described by 4 people, 1.5%, and a history of problems with authority was identified by only 1 individual, .4%. No education risk factors were identified for 62 people, 23.2% of the sample.

When asked about protective factors in the education category, 84 people, 31.5%, stated that they had an interest in upgrading their skills and grade levels. 29 individuals, representing 10.9% of the sample, had realistic educational goals. There were 59 people, 22.1%, who reported having graduated from some type of high school. Only 1 person, .4%, stated that he or she had earned a general education degree (GED). Forty-seven individuals identified no protective factors for the education category.

Employment: risk and protective factors. There were 110 individuals who stated that they were currently unemployed, representing 41.2% of the sample. There was 24% of the sample, 64 people, who reported being frequently unemployed, meaning they had been unemployed more than once per year. A history of job performance problems, such as attendance or task completion, was described by 21 individuals or 7.9 % of the sample.

There were 5 people, 1.9%, who described a history of problems with co-workers.

However, 2.2%, or 6 people, identified no risk factors in the employment category.

In the protective factors for employment category, 61 people, 2.8%, reported having interest in securing employment. Forty-two people or 15.7% of the sample reported that they had realistic employment goals with respect to their skills and abilities. Confidence in ability to find employment or the ability to access the necessary employment resources was reported by 25.1%, 67 people in the sample. Twenty-three individuals, 8.6%, stated that they had a full time, part time, or seasonal job or that they owned their own businesses. There were 6 people, 2.2%, who stated they did volunteer work. Only 1 person, .4%, was scored with identifiable skills. No protective factors were identified by 20 individuals, representing 7.5% of the sample.

Medical-physical: risk and protective factors. Risk factors for the medical category showed that there were 16 responses from 6% of the sample who stated that they had no access to medical services. 3.4%, 9 people, stated that they had been hospitalized in the previous twelve months. The data showed that 195 individuals, or 73% of the sample, reported no medical risks.

There were 13 people, 4.9%, who reported being able and willing to access medical services as needed. 16.9%, or 45 people, showed evidence of compliance with medical intervention. A majority of the sample, 148 people, representing 55.4%, reported that they had or that they qualified for medical insurance benefits. Fourteen people, 5.2%, did not endorse any medical protective factors.

Mental health: risk and protective factors. Treatment for a past or a chronic condition as an outpatient was reported by 46 individuals, 17.2% of the sample. Treatment for a past or a chronic condition and hospitalization was reported by 21 people, 7.9%. Treatment for a current condition or recommended treatment was described by 2.6%, or 7 people. Four people, 1.5% of the sample, reported trauma and victimization, such as sexual or physical abuse, as an adult. Only 1 person, .4%, reported trauma and victimization, such as sexual or physical abuse, as a child. Safety and protection issues were reported by only 1 individual, .4% of the sample. 52.4% of the sample, or 140 people, did not identify any mental health risk factors.

From this sample, 7.9%, 21 people, stated that they had responded favorably to past mental health intervention or that they were not experiencing any current mental health difficulties. Twenty-two people, 8.2% of the sample demonstrated skills to cope with daily hassles and 160 individuals, 59.9%, demonstrated skills to cope with major life events. Only 1 person acknowledged his or her problems with mental illness. There were no mental health protective factors identified by 16 individuals, 6% of the sample.

Life/interpersonal skills and social network: risk and protective factors. Data results for the Life/Interpersonal Skills Risks category show that there were 49 people, 18.4% who stated they had poor life skills, such as difficulty handling money, shopping, cooking, and taking care of their personal hygiene. Twenty-one people or 7.9% of the sample reported that they had poor social skills; 33 individuals, 12.4% reported that they had poor problem-solving skills, and 31 people, representing 11.6% of the sample stated that they were shy or withdrawn. Only 1 individual was unable to identify more than two

people who would assist him or her in crisis. No risk factors, in the life/interpersonal skills category, were endorsed by 31.8%, 85 people in the sample.

There were 28 individuals, 10.5% of the sample, who reported having good interpersonal skills and were able to communicate their needs. One hundred, eighteen people, 44.2%, were willing either to follow a recommended course of intervention or did not require any intervention. Only 5 people, 1.9%, reported that they had completed a life skills curriculum, such as Money Smart or Parenting. It was reported by 19.1% of the sample, 51 individuals, that they had regular weekly contact with friends who were supportive. 9 people, 3.4%, showed empathy, sensitivity, and friendship skills. 9 other people, also 3.4%, did not identify any protective life/interpersonal skills.

Substance abuse: risk and protective factors. Results show that 18 people, acknowledged that they had an alcohol problem in the past; however, 2.6% of the sample, 7 people, acknowledged having a current problem with alcohol. Two people, representing .7% of the sample, stated that they had a drug problem in the past and the same percentage was reported by those stating that they had a current drug problem. Substance abuse contributing to law violations was reported by 3 people, 1.1% and only 1 person, .4%, identified how substance abuse had contributed to his or her marital or family problems. One hundred, eighty-seven individuals, representing 70%, did not identify any substance use risks.

There were 22 individuals, 8.2%, who stated they had a favorable response to past substance abuse intervention or that they had never required intervention for substance abuse. A majority of the sample, 63.7% or 170 people, reported that they were not currently at risk for substance abuse and 2 individuals, .7%, stated that they were

currently enrolled in substance abuse treatment. No protective factors in the substance use category were endorsed by 26 people, 9.7%.

Criminal behavior: risk and protective factors. Having more than three adult convictions was reported by 22 people, representing 8.2% of the sample and 6 individuals, 2.2%, stated that they had current convictions. Three people, 1.1% reported that they had been arrested before the age of 16 and .7%, 2 individuals, had been incarcerated upon conviction. Only 1 individual reported that he or she had an official record of sexual offense. One hundred, eighty-six people, 69.7%, indicated that they had no criminal behavior risk factors.

A large majority of individuals, 169 or 63.3%, showed no evidence of anti-social behavior. Results indicated that 30 people displayed commitment to resist criminal behavior, representing 11.2% of the sample. Only 1 person reported having a probation or parole officer. Twenty individuals or 7.5% did not identify any criminal behavior protective factors.

Family of origin and current: risk and protective factors. The LNI assessment tool allows for two separate categories pertaining to family: family origin and family current. Unfortunately, when this information was collected, individual items were not recorded in the archival data. This makes it difficult to separate which factors refer to the family origin category and which refer to the family current category. It will be important, for future research on the LNI, to separate these two categories during data collection. A family total category was used to report family risk factors and family protective factors.

The percentage of individuals reporting no family risk factors was 32.6%, or 87 people. There were only 2 individuals, .7%, who did not report any protective factors. Unfortunately, the analyses were not able to examine any of the specific items related to either family origin or family current. This is problematic, primarily because no inferences can be made regarding the contributions of either category to risk or to protective totals. For instance, there is no way to describe the individual variables which make up the total risk score or the total protective score for family origin or family current. This is a significant issue because a separation of the family origin and family current categories could uncover significant relationships that may exist between familial discord and homelessness, as well as between familial support and protection against homelessness.

Children and dependents: risk and protective factors. For this sample, 43 people indicated that their child or their children had a juvenile criminal history. This represented 16.1 % of the sample. There were 26 individuals, 9.7%, who stated that their child or their children had a history of mental illness or behavior problems. Four people, representing 1.5%, identified chronic mental issues in their child or their children and only 2 individuals identified their child or their children as being hyperactive or diagnosed with ADHD (Attention Deficit Hyperactivity Disorder). The majority of people, 137 or 51.3%, did not identify any risk factors associated with their child or their children.

There were 117 people, representing 43.8 % of the sample, who did not endorse any protective factors in the Child/Dependents category. Having positive support from a non-custodial parent was reported by 24.3% of the sample, or 65 people. There were 26

individuals, or 9.7%, who identified their child or their children as receiving SSI (Social Security Insurance) and 3 people, representing 1.1 % of the sample, reported that they were receiving a childcare subsidy. Only 1 person, .4%, reported having school aged children enrolled in school.

Neighborhood: risk and protective factors. There were 19 individuals, 7.1%, who reported being disappointed with their accommodations and felt unsafe in their neighborhoods. A majority of people in the sample, 166 or 62.2%, did not participate in organized community activities. There were 35 people, 13.1%, who did not indicate any neighborhood risk factors.

There were 3 individuals, or 1.1% of the sample, who believed that community resources were helpful. 6.4% of the sample, 17 people, felt valued as contributing members to the community. A large majority, 198 people, representing 74.2% of the sample were willing to access services as needed. There were only 2 individuals, .7% who were either involved in leisure interests or who participated in community activities or both.

Risk and Protective Correlations

Tables 1.1 and 1.2 show correlations between all of the risk and protective factors on the LNI. Each of the 12 risk factors were evaluated against the other 23 risk and protective factors and each of the 12 protective factors were also evaluated against the other 23 risk and protective factors. Several of the significant correlations which were uncovered were expected, however several other significant correlations found were not.

Table 1.1

Intercorrelations for Risk Factors on the LNI

LNI Factors	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
HomeR	--																							
FinR	.26	.16	--																					
EduR	.10	-.32	.06	-.12	--																			
EmpR	.18	-.12	.23	-.25	.27	.14	--																	
MedR	.27	.11	-.00	-.03	.02	.32	-.09	.07	--															
MHR	.28	-.01	.06	-.06	.10	.19	.21	.04	.30	-.37	--													
LSR	-.10	-.26	-.04	-.11	.12	-.29	.11	-.12	-.01	.23	.02	.01	--											
SUR	.03	.05	.20	.08	.13	.23	.20	.08	.05	-.28	.10	-.15	.00	.06	--									
CrimR	.06	.06	.04	.01	.17	.37	.16	.11	.27	-.37	.17	-.13	-.09	.14	.42	-.31	--							
FamR	.28	.09	-.05	.04	.42	.43	.33	.18	.25	-.38	.47	-.06	-.06	.12	.36	-.20	.36	.28	--					
ChildR	.14	.20	.01	.10	.00	.19	.07	.15	.14	-.14	.13	-.02	.04	.11	.22	-.08	.21	-.01	.19	.03	--			
NeighR	-.42	-.16	-.18	.03	-.03	-.61	-.27	-.18	-.30	.70	-.37	.35	.28	-.05	-.29	.58	-.32	.04	-.41	.08	-.37	-.59	--	

Note All correlations are significant at $p > .10$.

Table 1.2

Intercorrelations for Protective Factors on the LNI

LNI Factors	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
HomeP	.11	--																						
FinP	-.09	.42	-.18	--																				
EduP	.28	.37	.08	.18	-.15	--																		
EmpP	.08	.31	-.04	.53	-.28	.41	-.04	--																
MedP	-.31	-.00	-.13	.22	-.07	-.53	-.36	-.00	-.24	--														
MHP	-.11	.12	-.33	.21	-.05	-.09	-.30	.14	-.11	.59	-.22	--												
LSP	.00	.63	.02	.44	-.18	.41	-.11	.32	.05	.12	-.21	.37	-.45	--										
SUP	-.25	.02	-.13	.16	-.13	-.34	-.25	-.00	-.29	.61	.18	.46	.16	.21	-.25	--								
CrimP	-.03	.15	-.03	.22	.02	.22	-.03	.25	.12	-.09	.10	.20	.10	.34	.24	.28	.33	--						
FamP	-.02	.08	-.06	.23	.07	-.06	-.03	.08	-.11	.22	-.13	.20	-.12	.30	-.15	.08	-.01	-.05	-.27	--				
ChildP	.36	.20	.15	-.05	-.02	.44	.17	.22	.37	-.44	.20	-.12	-.22	.10	.12	-.31	.28	.03	.32	-.04	.37	--		
NeighP	-.12	.01	.07	.15	.07	.00	-.09	.12	-.23	.23	-.44	.09	-.10	.24	.01	.11	-.04	.00	-.08	.22	-.05	-.04	.09	--

Note All correlations are significant at $p > .10$.

1 HomeR = Homelessness Risk; 2 HomeP = Homelessness Protective; 3 FinR = Financial Risk; 4 FinP = Financial Protective;
5 EduR = Education Risk; 6 EduP = Education Protective; 7 EmpR = Employment Risk; 8 EmpP = Employment Protective;
9 MedR = Medical Risk; 10 MedP = Medical Protective; 11 MHR = Mental Health Risk; 12 MHP = Mental Health Protective;
13 LSR = Life and Interpersonal Skills Risk; 14 LSP = Life and Interpersonal Skills Protective; 15 SUR = Substance Use Risk;
16 SUP = Substance Use Protective; 17 CrimR = Criminal Risk; 18 CrimP = Criminal Protective; 19 FamR = Family Total Risk;
20 FamP = Family Total Protective; 21 ChildR = Children Dependents Risk; 22 ChildP = Children Dependents Protective;
23 NeighR = Neighborhood Risk; 24 NeighP = Neighborhood Protective

Homelessness Risk

A correlational research design was used to determine the relationships that existed between risk factors and protective factors identified by the LNI. When the dependent variable was homelessness risk, the significant predictors were found to be risk factors from the finance, employment, medical, mental health, and neighborhood categories, and surprisingly, protective factors from the neighborhood, education, medical, and children and dependents categories were also found to be predictive of homelessness risk. It was expected that several of the other risk factors would correlate significantly with the homelessness risk factors, and many of them did. However, a closer examination of how protective factors were also correlated with homelessness risk is needed.

Protective factors from the neighborhood and education categories were found to be predictive of homelessness. It is not clear why the specific variables in the neighborhood protective category would predict homelessness. For example, if a person believes community resources are helpful, feels valued as a contributing member to the community, is willing to access services as needed, or is involved in leisure interests and participates in community activities, it would be expected that he or she would have more stability in his or her specific neighborhood. Also, with respect to the education category, if an individual shows interest in upgrading his or her skills and grade level, has realistic educational goals, has graduated from high school or earned a GED, or has completed some college courses, it would be expected that he or she would have more skills with which to make himself or herself more employable. Employability may lead to a more

stable financial situation, which is crucial to being able to maintain housing. More research on the LNI is needed to understand these correlations fully.

Regardless of an individual's satisfaction with his or her current neighborhood, or his or her high level of education, it is possible that other issues may override these protectors. For instance, if substance use is a problem, many protective factors may not be strong enough to overcome the devastating financial and emotional effects of the substance use, and a person may not be able to maintain his or her housing. Interestingly, risk factors in the substance use category did not correlate significantly with risk factors in the homelessness category. Perhaps, this is because substance use may have been underreported in this sample. Or, it may simply be that on their own, specific risks, such as those found in the substance use category, are not significant enough to affect homelessness; however, when combined with other risks in other categories, substance use becomes significant.

Ability and willingness to access medical services as needed is considered a protective factor on the LNI and, in fact, may protect a person against the development of chronic conditions, as a result of a lack of attention to initial signs and symptoms. This may be viewed as a positive situation for health reasons, however co-pay requirements from frequent visits to physicians and hospitals, as well as paying for prescription medications, can be costly and may lead to having less money left over to pay for housing. This is assuming that the individual has medical insurance coverage and is not paying for medical services on his or her own. If the latter is the case, the costs can be even more overwhelming and would, most likely, affect a person's ability to maintain housing if he or she is currently struggling financially. A lack of health insurance

coverage may negatively affect a person's willingness to access needed medical services; however, if this fact does not deter a person without healthcare coverage in seeking health care, considering the high cost of healthcare, it would be understandable that this individual would eventually have financial difficulty if his or her health conditions became severe enough.

The children and dependents protective category was also found to predict homelessness risk. Having positive support from a non-custodial parent is considered protective because a single parent would not need to bear the burden of caring for and supporting a child or children alone. This may protect the parent financially, as well as emotionally, and aid the parent in the stable maintenance of housing. However, the fact that the parent is caring for his or her child or children alone may simply be so strong a factor that the protection non-custodial support can provide is not enough to overcome the effect. Similarly, if a child receives SSI or the parent receives a childcare subsidy, there may already be some risk factors that exist, which may be working against any protective effects that this variable provides.

Homelessness Protective

When the dependent variable was homelessness protective, the significant predictors were found to be protective factors from the child and dependents, criminal behavior, finance, education, and employment categories, as well as risk factors from the education, finance, life and interpersonal skills, medical, and employment categories. It had been expected that protective factors from several categories would correlate positively with factors in the homelessness protective category. However, it is not clear

why some risk factors also correlated positively with factors in the homelessness protective category.

It was not anticipated that education risk factors would predict protection against homelessness. It is reasonable to assume that when an individual has less than a tenth or even a twelfth grade education, the reason may be that he or she had academic difficulties, possibly because of a learning disorder, low intelligence, or a developmental disability. These factors would not ordinarily be seen as predictors of protection against homelessness. Also, if a person has had a history of behavioral problems, such as aggressiveness, impulsiveness, ADHD, ODD (Oppositional Defiant Disorder), or CD (Conduct Disorder), it would not be naturally assumed that these factors would protect this person from homelessness. A closer look at LNI data may uncover the relationship between these seemingly unrelated factors.

Finance risk factors were found to predict protection against homelessness. This is surprising considering some of the factors in this category, such as no finances or limited finances to support basic needs, history of financial instability, and a court order to pay child support. Financial risk factors may be thought of as some of the most significant to consider when predicting homelessness risk. It is unclear why the factors in this category were found to be significant in the prediction of protection against homelessness.

It was not expected that risk factors from the life and interpersonal skills category would predict protection against homelessness. If a person has poor life skills, such as difficulty shopping, cooking, taking care of his or her personal hygiene, and handling money, it may be assumed that these issues would contribute to homelessness risk as opposed to protecting against it. Again, a deeper investigation must be conducted in an

effort to uncover why the findings in this study were so contradictory to that which was expected.

Difficulty with interpersonal interactions, such as poor social skills, poor problem-solving skills, being shy or withdrawn, isolating oneself socially, and being unable to identify more than two people who would assist in a crisis would seem to be more closely associated with homelessness risk, not protection from homelessness. This is another unanticipated finding from this study. Future research must be conducted to ascertain whether or not use of the LNI will be able to produce a normative data set.

It is unclear how having no access to medical services would be predictive of protection against homelessness. However this was the finding with regard to the medical risk factors category. Another factor in this category which was found to predict protection against homelessness is conceivably more understandable. Perhaps having been hospitalized at some time in the previous twelve months can be viewed as protective because the individual may have received the services necessary for him or her to be able to continue to function in daily life. Even if this explanation is applicable, more attention must be given to the predictive qualities of the LNI.

Factors in the employment risk category were found to be predictive of protection against homelessness. Some factors which may have contributed to this finding were being currently unemployed, frequently unemployed, meaning more than once per year, a history of job performance problems, such as poor attendance or difficulty in completing tasks, history of problems with co-workers or a boss, and no identifiable job-related skills. It is not clear how these factors predict protection against homelessness. In fact, at

first glance, it may initially be assumed that these factors would contribute significantly to homelessness risk.

One explanation might be identified by exploring the fact that no one in the sample endorsed that they had ever leased or rented their own homes. Many individuals in the sample who endorsed some of the other items in the employment risk category may have been living in housing that was owned or leased by family members or friends. Or perhaps these individuals were on public assistance before becoming homeless and felt that this homelessness occurrence was not a permanent situation or was anything that they could not rectify with the continued help from public assistance. The factors from the homelessness protective category that were used in this analysis were confidence in ability to resolve the housing situation, ability and willingness to access community resources, and ever having paid utilities. However, leased or rented own home was not endorsed by anyone in the sample and this information might indicate that confidence in the individual's ability to resolve his or her homeless situation was related more closely to an ability to find another friend or family member to move in with, or perhaps to his or her ability to continue to be eligible for public assistance, than it was actually related to the individual's ability to provide a suitable place to live for himself or herself and for his or her children .

There were several unanticipated findings uncovered during this study. Some possible explanations have been identified and described here, however more comprehensive research must be conducted in order to identify the true relationships between the factors on the LNI. It will be essential for this study to be replicated after adjustments have been made to more accurately collect, score, and record data. An

examination should also be conducted to ascertain whether or not each risk and protective factor located in each of the 13 categories are in fact representative of risk for or protection against homelessness. This is discussed further in the Recommendations section.

Discussion

The aim of this study was to identify predictors of homelessness using a sample of 267 adult homeless clients who were temporarily housed in one of three VOADV homeless shelters. The information taken from the LNI data is representative both of risk factors and of protective factors for homelessness. Each category on the LNI lists several risk variables and protective variables which are thought to correlate with homelessness and secured housing respectively. More specifically, the variables from the 12 LNI categories are thought to be predictive of the 13th category on the LNI, which is homelessness. In other words, the risk factors in the other 12 categories are thought to be predictive of the risk factors in the 13th category, homelessness, and the protective factors in the other 12 categories are thought to be predictive of the protective factors in the 13th category, homelessness.

Results of this study show that not only did some risk factors predict homelessness risk, but also some protective factors were predictive of homelessness risk as well. In addition, although some protective factors were predictive of protection against homelessness, some risk factors were also found to be protective against homelessness. Factors on the LNI, which are assumed to be protective, may not truly be protective and those that are thought of as risk factors for homelessness may not always be predictive of homelessness risk.

Several correlations in this study identify the opposite of that which would be expected if the LNI is to be used as a reliable measure of risk and protective factors for homelessness. It is possible that several problems existed, which led to these results and

these problems must be identified and corrected before further research can be conducted on the LNI. Some of these issues are addressed in the Limitations section.

Limitations

The results identified from this data set are somewhat surprising, considering the correlations that were expected. The VOADV has been using the LNI to assess homeless clients' needs by attempting to identify risk factors that may prevent clients from reaching goals and protective factors that may assist clients in reaching their goals. At the onset of this study, it was hypothesized that risk factors for homelessness would correlate with risk factors from the other 12 categories and protective factors for homelessness would correlate with protective factors from the other 12 categories. Although it was found that several homelessness risk factors did correlate with several risk factors from some of the other categories, and several homelessness protective factors did correlate with several protective factors from some of the other categories, it was also found, unexpectedly, that some protective factors were correlated with the homelessness risk category and some risk factors were correlated with the homelessness protective category.

There are several limitations associated with this study and these limitations may account for the unexpected results. Perhaps there may have been some anomalies in the data set that contributed to the unanticipated findings. Because all of the data used in this study was archival, was obtained from separate facilities, and was collected and recorded by different raters, there may have been some differences in the methods used to obtain and collect the data; these could have affected the results. Also, the amount of missing

data may have added to the unpredicted outcome of this study. The way in which the data was reported made it impossible to use the same individuals for each analysis.

Another consideration is whether or not the clients themselves were accurate historians in providing information to the raters. Because of the self-reporting nature of the LNI, raters must often rely on the information they are given and they may not always receive completely factual information. Even when using the scoring criteria, it is possible that a client could mislead a rater. This may be due to a client's mistrust of the rater or his or her discomfort with being in the shelter facility. The client may not want to disclose this personal information, or he or she may simply be willing, but unable to give an accurate account of previous events because of medical or psychological constraints. It may not always be possible for raters to obtain accurate scores, based solely on the ratings given by the clients themselves. However, the ratings that are obtained may still be more helpful than having no information at all on which to base service decisions.

Recommendations for Future Research

Additional studies are required in order to validate the LNI appropriately. Before this is possible, a more stringent standardization of the procedures used to administer and score the LNI may also be necessary. Accurate collection and recording of client information will be as crucial to the validation process as is the actual reporting of the information from the client. All data must be collected, scored, and recorded in a similar fashion.

Data should be collected in a manner that allows for the 145 individual items, within the 13 categories of the LNI, to be identified separately. This will allow inferences to be made about whether or not these individual items actually represent risk or

protection and, if so, which items have the greater strength. With the identification of individual items, categories as overall predictors can be better established. If categories are not found to be accurate predictors, an analysis of individual items can be conducted to uncover which specific items are not representative. If the representations are found to be accurate, analyses can then be conducted to uncover the value of each item as a contributor.

Continued use of the LNI may provide more information regarding its true abilities to assess risk factors and protective factors for homelessness. Eventually a normative data set can be produced and these norms can be used as a comparative measure for other samples. It is only with continued research that the LNI's true predictive qualities can be ascertained.

Conclusions

The hope is that this preliminary study, followed by additional research, will provide a better understanding of the effectiveness of the LNI. The eventual development of a set of norms for the LNI will be useful to the VOADV, as well as to other service organizations that work with the homeless population.

The field of psychology will benefit greatly from the validation of the LNI. Service organizations and treating psychologists will be better able to focus on and measure clients' strengths and weaknesses, as well as to direct clients to necessary resources more quickly and efficiently. It is anticipated that the effective assessment of homeless clients will lead to appropriate referrals for services and serve as a therapist guideline for psychological treatment.

Psychosocial stressors alone can lead to emotional disturbance; however, when combined with medical or mental health problems, the consequences can be devastating and paralyzing. The LNI's ability to yield an accurate representation of the specific variables which hinder a person from reaching the goal of maintaining housing, as well as what variables aid him or her in the attainment of permanent housing, will be of benefit, not only to service organizations and treating psychologists, but more importantly to the individuals whom these organizations and psychologists assist.

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